Continuing Your Medical, Dental, Life, and LTD Benefits During Temporary Loss of Pay Status

Important Note: Your employer will no longer contribute toward your insurance benefits (including medical, dental, basic life, and long-term disability coverage) when you temporarily lose pay status (for example, due to educational leave, leave without pay, reduction in force, reversion, or while you are receiving time-loss benefits under workers' compensation). However, you have the right to self-pay your premiums and keep some coverages in effect under rules of the Public Employees Benefits Board (PEBB). You may also take up to 12 weeks of unpaid family medical leave and retain your employer-provided benefits. To continue coverage on a self-pay basis, you must submit an enrollment form within 31 days following the date your employer-provided benefits end. Premiums must be paid retroactive to the first day of the month following termination of employer-provided benefits.

This instruction sheet (a) describes your rights under PEBB rules, (b) specifies what you must do to maintain your coverage, and (c) lists the current premium rates for continuation of coverage. When you return to work, the employer contribution will be reinstated on the first of the month in which you return to eligible employment if you self-paid your medical premiums. If you did not self-pay medical premiums, benefits will begin on the first of the month following your return to work in an eligible position. Certain optional benefits that you have not self-paid while away from work may have to be applied for and approved again (see below). **Note**: WAC 182-12-121 applies to reduction-in-force employees.

Medical and Dental Benefits

You may continue your PEBB medical and dental coverage at the group premium rate by self-paying your premium for up to 29 months. You may continue medical coverage only, medical and dental together, or dental coverage only. You are not allowed to change medical or dental plans at the time you choose to continue your benefits on a self-paid basis. You will be allowed to change health plans only during an open enrollment period or when you move out of your plan's service area.

Part-time faculty may choose to continue PEBB medical, dental, and life insurance benefits between periods of employer-sponsored coverage for a maximum of 18 months.

You must submit a self-pay enrollment form and pay the first month's premium before self-paid coverage will begin. The premium you pay will be based on the plan you are enrolled in and the number of dependents you cover. The medical and dental premium rates, based on family size, are included in this packet.

Life Insurance Benefits

You may continue all or part of your life insurance coverage on a self-paid basis for up to 29 months. If you choose to continue any part of your optional life coverage, you must also continue the $15,000 basic coverage at a cost of $3.01 per month.

If you self-pay for a reduced amount of optional coverages, you must reapply to increase your life insurance coverage when you return to active employment. Please note the following:

1. If you continue Part B Spouse Supplemental coverage, you must also continue Part B Basic Spouse coverage. The amount of Part B Spouse Supplemental coverage continued while you self-pay cannot exceed the coverage you had as an active employee.

2. If you are called to active military duty, all life insurance coverage ceases at the end of the month in which you begin active duty. If you are called to military duty for 31 days or more, you may extend coverage for Parts B, C, and D to the end of the 12th calendar month in which your active duty began. There are two options for extending insurance benefits:

   a. You can use agency approved annual or military leave to maintain a minimum of eight hours pay status each month. Employer-sponsored Part A will be continued. You are responsible for paying the premium for continued coverage of Parts B, C, and D.
   b. You can self-pay your life insurance coverage. Contact your personnel, payroll, or benefits office to obtain the form required to self-pay your coverage.

   If you return to full-time employment status before the end of the 12th calendar month in which you began active duty, you may reinstate your original coverage without proof of good health. If you return to full-time employment status after the end of the 12th month in which you began active duty, you may be required to provide proof of good health to obtain coverage under Parts B, C, and D. Upon your return to work, any increase to the amount of life insurance you had in place when you were called to active duty will require proof of good health.

When you return to work, you will need to complete the *Life Insurance Enrollment/Change Form* within 31 days in both situations to reinstate your coverages:

- If you choose to self-pay optional coverage during a leave without pay, coverage will be reinstated as an active employee when you return to work without providing evidence of good health.

- If you choose not to pay for optional coverage, you will have to submit evidence of good health when you return to work.

Long-Term Disability Benefits

Neither basic nor optional long-term disability (LTD) coverage may be continued by self-payment unless you are on an approved educational leave. Your payroll/insurance office has a definition of educational leave for this purpose. If you qualify for continuation of LTD coverage and choose to do so, you must pay the $2.70 premium for basic LTD coverage if you want to continue under the optional LTD plan.

Optional LTD coverage dropped during a leave without pay will be reinstated when you return to work without providing evidence of good health.

Making Premium Payments

With few exceptions, your employer will pay the basic coverage premium for any month during which you were actively employed (in pay status) for eight hours or more. If you wish to continue optional life insurance coverage, any part of the premium due for the month in which your leave begins that was not deducted from your pay must be paid to the Health Care Authority (HCA) with the next full month's premium.

How to Arrange Self-Paid Continuation of Your Benefits

If you are eligible and want to continue your group coverage by self-paying your premiums, complete the following steps:

1. You must submit a *Self-Pay Medical and Dental Coverage* form for the coverages you want to continue within 31 days following the date employer-provided benefits ends. Send the completed form, together with a check for the first month's premium, to:

   Washington State Health Care Authority
   P.O. Box 42695
   Olympia, WA 98504-2695

   Make check payable to the Washington State Treasurer.

2. After you make your first payment, your premiums will be due on the 15th of each month of coverage, and will be past due on the 23rd. Late payment of your premium or return of your check for insufficient funds will be cause for cancellation of your coverage without notification, effective on the first day of the month for which the premium was not paid in full or on time.

3. If you wish to make any changes in your coverage while you are self-paying your premiums, **contact the Health Care Authority**, not your agency.

4. If you wish to terminate your coverage with the HCA, you must submit a written request. Termination will be effective the first day of the month following receipt of the termination notice.

Where to Go for Assistance

1. **Within your agency or higher-education institution:** The payroll, personnel, or insurance department (or retirement/insurance office for retirees) can assist you with forms and can answer general questions about self-pay eligibility.

2. **Within the Health Care Authority:** If you are unable to get the information you need from your agency or higher-education institution, the HCA's benefits specialists can help with your questions about HCA and PEBB policies, plan eligibility and enrollment, self-pay continuation, or conversion of coverage.

   Olympia and vicinity 360-412-4200
   Outside Olympia 1-800-200-1004

Health plan comparisons in this document are based on information believed accurate and current, but be sure to confirm data before making decisions.

Some benefits described in this booklet are based on state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Public Employees Benefits Board (PEBB)

2003 Self-Pay Medical and Dental Coverage

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- All covered family members must be included on this form.
- Make checks payable to the State Treasurer.

SECTION 1: Subscriber Information

Date employer coverage ended

Social security number | Sex ❑ M ❑ F | Last name | First name | Middle initial

Address | Apt./unit number

City | State | ZIP Code | County of residence

Date of birth (mm/dd/yyyy) | Work phone number (including area code) | Home phone number (including area code)

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their preferred providers and require you to choose a primary care provider. **Contact your plan for code.** ➡ Physician or clinic code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only ❑ Life insurance

Are you part-time faculty? ❑ Yes ❑ No

Reason for self-pay: ❑ Leave without pay ❑ Reduction in force ❑ Family Medical Leave Act ❑ Educational leave ❑ Other

SECTION 2: Family Member Information

List only family members you wish to cover.

Relationship to subscriber
❑ **Spouse** OR ❑ **Same-sex domestic partner** | Social security number | Physician or clinic code (contact plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

Other Family Members (such as child, grandchild, etc.) ***Use additional forms for more members***

A **Relationship to subscriber** | ❑ Disabled? ❑ Student? *(Check only if age 20 or older.)* | Sex ❑ M ❑ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

B **Relationship to subscriber** | ❑ Disabled? ❑ Student? *(Check only if age 20 or older.)* | Sex ❑ M ❑ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

SECTION 3: Changes

(Check all that apply.)

Subscriber changed: ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan

I wish to cancel **medical** coverage. ❑ Yes ❑ No

I wish to cancel **dental** coverage. ❑ Yes ❑ No

Change in family status:

❑ **Adding a spouse or same-sex domestic partner.** You **must** complete a Declaration, available from the Health Care Authority or online at www.pebb.hca.wa.gov

❑ **Adding family member A**

❑ **Adding family member B**

❑ **Widowed** Date (mm/dd/yyyy)_____

❑ **Removing a spouse or same-sex domestic partner from coverage.** Please provide his/her new address, date of event, and reason:

Address _____

_____

Date (mm/dd/yyyy) _____

Reason _____

❑ **Removing other family members from coverage**

Name _____

Date (mm/dd/yyyy) _____

SECTION 4: Medical Plan Selection

(Check only one.)

❑ Group Health Cooperative of Puget Sound

❑ Group Health Options, Inc.

❑ Kaiser Foundation Health Plan of the Northwest

❑ PacifiCare of Washington, Inc.*

❑ Premera Blue Cross

❑ RegenceCare*

❑ Uniform Medical Plan

** These plans require the physician or clinic code of your selected primary care provider. Contact plan for code.*

SECTION 5: Dental Plan Selection

(Check only one.)

Preferred Provider Organization

(may receive services *from any provider*):

❑ Uniform Dental Plan (Group #3000)

Managed Care Plans

❑ DeltaCare (Group #3100)
Dentist name _____
(must receive services from *DeltaCare provider*)

❑ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Columbia Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

SECTION 6: Life Insurance

Current Enrollment with Agency

☒ Basic Part A (employer paid)

	Coverage Amount
❑ Part B–Dependent/Children	
❑ Part B–Spouse	
❑ Part B–Supplemental Spouse	_____
❑ Part C	_____
❑ Part D	_____
❑ Part E with Dependents	_____
❑ Part E without Dependents	_____

Desired Enrollment while Self-Paying

❑ I wish to maintain the same coverage I had as an active employee. _____ ***(initials)***

❑ I do not wish to continue the life coverage while eligible for self-pay, and **I understand that I must provide evidence of good health to reinstate optional life insurance when I return to work.** _____ ***(initials)***

SECTION 7: Long-Term Disability

This section applies ONLY to employees on educational leave.

Current Enrollment with Agency

☒ Basic Part A (employer paid)

❑ 30-Day ❑ 60-Day ❑ 90-Day ❑ 120-Day ❑ 180-Day ❑ 240-Day ❑ 300-Day ❑ 360-Day

Desired Enrollment while Self-Paying

❑ I wish to maintain the same coverage I had as an active employee. _____ ***(initials)***

❑ I do not wish to continue the long-term disability while eligible for self-pay. _____ ***(initials)***

SECTION 8: Signature (Required)

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority. I certify that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all previous forms I have submitted for Public Employees Benefits Board medical/dental coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____

Subscriber's signature Date

Please sign and date this form.

Return form to: Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695

Washington State Health Care Authority
Public Employees Benefits Board